Eric Udell, ND
Danite Haller, ND
1250 E Baseline Rd., Suite 104
Tempe, AZ 85283
Laurinda Kwan, ND

Medical Intake Form

Date:

Patient Name: _____Age :_____ Date of Birth:_____

Gender: Female Male Marital Status: #Children:

Address:_____City:_____State: ____ Zip:_____

Home Phone: _____Cell Phone:_____

Work Phone: E-mail:

Person to Contact in Case of Emergency:_____

Relationship to Patient:_____

Phone:

How Did You Hear About Us?

□ Yellow Pages □ Other Practitioner Who?_____
□ Internet □Current Patient Who? _____
□ Our Website □Other _____

If patient is a Minor, Name of Parent/Guardian(s)

_____

Patient Signature: _____ Date: _____

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HEALTH CONCERNS	**HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESSES**
Please list your current health concerns in order from most bothersome to least bothersome. Please include Mental, Emotional, and Physical concerns 1) _____ 2) _____ 3) _____ 4) _____ 5) _____	Date / Condition or Procedure 1) _____ _____ 2) _____ _____ 3) _____ _____ 4) _____ _____ 5) _____ _____

MEDICATIONS

Please list the medication and dosages that you are currently taking. Please include both prescription and over the counter.

	Medication	Dosage
1)		
2)		
3)		
4)		
5)		
6)		

SUPPLEMENTS

Please list all of the supplements that you are currently taking including dosages and brand names.

	Supplement	Dosage	Brand
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

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ALLERGIES

Please list any medication, food, environmental or other allergy.

1) _____
2) _____
3)

FAMILY HISTORY					
	Children	**Mother**	**Father**	**Siblings**	**Grandparents**
Thyroid Problems					
Diabetes					
Tuberculosis					
Hypoglycemia					
Stroke					
Heart Attack					
Epilepsy/Seizures					
Cancer					
Asthma					
Allergies					
Anemia					
Migraines					
Hepatits					
Heart Disease					
Birth Defect					
High Blood Pressure					
Gall Bladder					
Arthritis					
Alcholism/addiction					

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NOW	PAST	GENERAL SYMPTOMS
		Tired, weak, lack of energy
		Depression, moodiness
		Worry, anxiety, nervousness
		Sleeplessness or too much sleep
		Frequent colds or other illnesses
		Headaches
		Dizziness, fainting, blacking out
		Don't sweat enough/too much sweat nightsweats

NOW	PAST	EARS
		Earaches
		Noises or ringing in ears
		Ear discharges
		Loss of hearing
		Excess earwax
		Difficulty hearing

NOW	PAST	SKIN & HAIR
		Acne or pimples
		Hives
		Stretch marks
		Skin ulcers or sores
		Dryness, roughness or scaling skin
		Hair loss or thinning
		Dry, course hair
		Bruise easily
		Nails weak, ridged or split easily
		Brown spots or bronzing on skin
		Warts, moles or skin tags
		Sunburn easily
		Cuts heal slowly or scar badly
		Flush easily
		Athletes foot.

NOW	PAST	GASTROINTESTINAL
		Loss of appetite
		Nauseau or vomiting
		Bad breath
		Metallic or bitter taste in mouth
		Heartburn
		Indigestion
		Heaviness after eating
		Bloating or gas
		Belching
		Constipation
		Diarrhea
		Light colored or greasy stools
		Undigested food in stool
		Blood in stool or on paper
		Hemmorrhoids
		Foul odor of stool or gas
		Rectal pain/itching

NOW	PAST	EYES
		Nearsightedness or farsightedness
		Blurred or failing vision
		Dry, burning or itching eyes
		Eyes water excessively
		Night blindness
		Bloodshot, red or puffy eyes
		Mucus or discharge in eyes
		Pain in eyes

NOW	PAST	CHEST
		Cough frequently
		Spitting up mucous or blood
		Difficultly breathing
		Chest pain
		Wheezing
		Palpitations

NOW	PAST	NOSE & THROAT
		Allergies, sinusitis, runny nose
		Dry mouth or nose
		Nosebleeds
		Cracks in corners of mouth
		Dry or chapped lips
		Sore throats or tonsillitis
		Sore, red, or cracked tongue
		Cold sores or herpes
		Loss of smell or taste
		Bleeding gums
		Hoarseness
		Grinding teeth
		Dental problems
		Difficulty swallowing

NOW	PAST	CARDIOVASCULAR
		Heart beats fast or irregularly
		Tighness in chest
		Discomfort in high altitude
		Dizzy or weak on standing
		Swollen feet, ankles or legs
		Cold hands or feet
		Hands or feet turn blue
		Leg pain with walking
		High blood pressure
		Low blood pressure

NOW	PAST	URINARY
		Difficulty urinating
		Urinate frequently at night
		Bed Wetting
		Incomplete urination or dribbling
		Pain when urinating
		Bladder or kidney infection

Ph (480) 456-0402 · Fax (480) 456-0409

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			Kidney stones
			Urine leakage
			Blood in urine

NOW	PAST	FEMALE
		Irregular periods
		Pain prior to or with periods
		Depressed irritable around periods
		Painful or swollen breasts
		Lumps in breast
		Nipple discharge
		Vaginal discharge
		Vaginal pain or itching
		Hot flashes
		Diminished or excessive sex drive
		Difficulty reaching orgasm
		Inability to conceive
		Miscarriages or abortions
		Pelvic pain
		Pain with intercourse
		Heavy periods

NOW	PAST	MALE
		Prostate problems
		Sexual difficulty
		Genital discharge
		Rashes or sores
		Pain in genitals
		Painful testicles
		Prostate problems

CONDITIONS

Please check any conditions you have had.

	AIDS		**Chemical Dependency**		**High Cholesterol**		**Prostate Problems**
	Alcoholism		**Chicken Pox**		**HIV Positive**		**Psoriasis/Eczema**
	Allergies		**Diabetis**		**Kidney Disease**		**Psychiatric Care**
	Anorexia		**Emphysema**		**Leg Cramps**		**Rheumatic Fever**
	Ademia		**Epilepsy**		**Liver Disease**		**Scarlet Fever**
	Appendicitis		**Gall Bladder Disease**		**Measles**		**Stroke**
	Arthritis		**Glaucoma**		**Migraine Headaches**		**Suicide Attempt**
	Asthma		**Goiter**		**Miscarriage**		**Thyroid**
	Bleeding Disorder		**Gonorrhea**		**Mononucleosis**		**Tonsilitis**
	Breast Lump		**Gout**		**Multiple Sclerosis**		**Tuberculosis**
	Bronchitis		**Heart Disease**		**Mumps**		**Typhoid Fever**
	Bulemia		**Hepatitis**		**Pacemaker**		**Ulcers**
	Cancer		**Hernia**		**Pneumonia**		**Vaginal Infections**
	Cataracts		**Herpes**		**Polio**		**Venreal Disease**

I certify that the above information is correct to the best of my knowledge.

Signature: _____Date:_____

Print Name: _____

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